MEDICINE.

UNDER THE CHARGE OF
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PRETUBERCULOUS POLYURIA.

DAVID has recently studied a new syndrome associated with beginning tuberculosis, which is stated to have been first discovered by A. Robin in 1894.

The main symptom consists of polyuria, which, in these cases, always precedes tuberculosis.

The disease is seen usually in young men of from twenty to thirty years of age, and with a nervous temperament.

The onset of the symptoms is usually abrupt, with fever, weakness, and pains in the loins, but these symptoms disappear in a few days, when the polyuria occurs.

Blood and fatty material are found in the urine, and the chlorides and phosphates are increased.

The thirst is much increased, as in all polyurias, but the appetite, instead of being increased, is diminished, and vomiting and diarrhœa may be observed.

Instead of the lowered temperature seen in ordinary polyuria, there is fever, and the temperature may be very irregular, with great oscillations.

The signs of tuberculosis may appear at the same time as the polyuria, or may not be made out until a short time after this.

The polyuria generally diminishes gradually after its sharp onset. The form of tuberculosis usually associated with this syndrome is a chronic one, with almost complete absence of hæmoptysis and night-sweats.

David thinks that the increased amount of urine should be kept up if possible, as it is a means of eliminating poisonous products.—*Revue de la Tuberculose*, December, 1895.

INTESTINAL CALCULI.

MONGOUR reports the case of a young woman of thirty-one years, arthritic and neurotic, who had suffered for six years from digestive disorders in the form of flatulent dyspepsia, with dilatation of the stomach. The symptoms of muco-membranous enteritis came on early in 1895, with sharp abdominal pain, tenderness along the course of the colon, and obstinate constipation. After passing a large amount of muco-membranous material over a period of six or seven months, the patient began to notice small stones in the passages.

Most of these stones were about the size of orange-seeds, the largest as big as a nut, and their discharge lasted two or three weeks. The concretions were of a yellowish-white color, and very friable, some of them presenting conical elevations on their surfaces, others smooth. They were homogeneous on section, and did not contain any central nucleus. Chemical examination showed the stones to be composed principally of carbonate of lime and phosphates of magnesia, with a small amount of organic matter, iron, and water.

The urine at the time that the stones were being passed was normal. Mongour thinks that the process of formation of these stones is similar to that of gall- and kidney-stones, and cites Dieulafoy as stating that he has seen several examples of the three forms of lithiasis in the same family.—*Comptes Rendus de la Société de Biologie*, February 28, 1896.

RUPTURE OF THE HEART.

KOUSKOFF reports a case of this rare occurrence which he says he has only observed three times in eight thousand autopsies.

The patient was a professor in the University of Kieff, in whom the autopsy was made fourteen hours after death.

The previous history of the patient was negative, and he was suffering at the time of death with symptoms of la grippe, which had lasted about ten days. The sputum had been bloody, likewise the stools, and there was slight cough, but the temperature had not risen above 37.5° C. Death occurred suddenly, the patient complaining of feeling faint a few moments before he died.

The autopsy showed a dilated pericardial sac containing seven hundred grammes of partly coagulated blood; a rupture of the heart was seen on removing this. The rupture was situated on the anterior wall of the left ventricle, and was about four centimetres in length. The heart was increased in size, and the whole wall of the left ventricle was bulged out, resembling an aneurism. The cardiac muscle in the neighborhood of the rupture was of a pale-yellowish color, soft, and entirely necrotic. In the descending branch of the left coronary artery, of which the origin was free, was a mixed clot two centimetres long, obliterating the lumen of the vessels. There was marked sclerosis of the aorta.

Kouskoff thinks that in this case the arterio-sclerosis led to thrombus-formation, and that a portion of the thrombus was dislodged and plugged the coronary artery. The necrosis of the heart-muscle resulted from this plugging, the actual rupture being probably due to undue stimulation of the heart, perhaps caused by catheterization, which had been practised just before death.—*La Presse Médicale*, March 18, 1896.

THE RELATION BETWEEN BRIGHT'S AND PROFESSIONAL CRAMP.

In a recent note **BONNIER** calls attention to the fact that it has long been known that Bright's disease may be associated with cramps of various kinds, and suggests that cases of professional cramp may be associated with Bright's.

He relates a case in point of an individual, a telegrapher, who, following an attack of smallpox, developed a professional cramp, and showed symptoms of nephritis. He was subjected to various treatments without avail, and finally underwent a great improvement on a milk-diet, the Bright's disease having been recognized by this time.

Bonnier suggests that the urine should be carefully examined in all cases of professional cramp, more especially in the chronic and obstinate cases.—*Comptes Rendus de la Société de Biologie*, February 21, 1896.

THE CLINICAL VALUE OF ELSNER'S METHOD OF DIFFERENTIATING THE TYPHOID BACILLUS.

In a recent article **CHANTEMESSE** calls attention to the value of the Elsner method of differentiating the typhoid from the colon-bacillus, and of isolating the typhoid bacillus from the stools.

He states that out of sixteen cases he was able to obtain the typhoid bacillus by this proceeding in thirteen, and notes that in two of the three unsuccessful attempts the failure was probably due to imperfect technique.

Of the thirteen cases three merit special attention, as the bacteriological examination was of great value in clearing up the diagnosis. In the first of these cases a young girl was admitted to the hospital, and after some days of fever a probable diagnosis of typhoid was made; the temperature, however, dropped suddenly, and the clinical diagnosis was doubtful, but was cleared up by finding the bacilli in the stools. A second patient was admitted in an alcoholic condition, complaining only of weakness. He had no fever, and at first was supposed to be a paretic with alcoholism, but an examination of the stools revealing the presence of typhoid bacilli, a history of a recent attack of typhoid was elicited.

A third patient was admitted to the hospital, afebrile, with photophobia; contraction of the fields of vision, and hemianæsthesia. The case was thought to be one of hysteria, but typhoid bacilli being found in the stools, a history of the patient having had fever, diarrhœa, and vomiting fifteen days before admission, was elicited.

Chantemesse points out the fact that by means of this medium an early diagnosis can be made, and obscure cases can be cleared up.—*Comptes Rendus de la Société de Biologie*, March 5, 1896.

PYLORIC STENOSIS FOLLOWING CHOLELITHIASIS.

BOUVERET, in a recent paper, records fresh cases of this form of pyloric stenosis, and states that it is, with the exception of very rare cases of congenital stenosis, the least common of all forms.

The author points out the close relations which normally exist between the gall-bladder and the pylorus, and observes how frequently adhesions take place between the two organs as a result of inflammation originating from one or the other.

The actual stenosis of the pylorus, after adhesions have formed, can occur in one of several ways: 1. From the organization and contraction of the plastic exudate resulting from the localized peritonitis. 2. From spasm of the plyoric sphincter caused by contraction of the loaded stomach or the irritation of neighboring inflammatory lesions. 3. From fixation of the pylorus by firm adhesions, the presence of food in the stomach pulling the organ down and causing an angular bend at the pylorus, which narrows its lumen. 4. From the presence of a large stone fixed in the duodenum, and either occluding it or the neighboring pylorus.

In arriving at a diagnosis of stenosis due to or following gallstones the author lays particular stress on eliciting a previous history of gallstone colic or of having passed gallstones per rectum.

The symptoms and signs are similar to those of pyloric obstruction from other causes for the most part.

One symptom, however, the author calls attention to in connection with the stenosis due to fixation of the pylorus, and this is that the vomiting and symptoms of dilatation persist as long as the individual is active and on his feet, but cease when he rests in a recumbent position.—*Revue de Médecine*, January, 1896.

THE RÔLE OF MICROBES IN THE FORMATION OF GALLSTONES.

GILBERT and **FOURNIER** publish an interesting account of their bacteriological researches upon gallstones, with relation to their causation.

The stones which they examined were obtained for the most part from human beings, in a few instances from cattle, the age of the stones varying in different cases.

In all the old gallstones, with one exception, cultures and cover-glass preparations were negative.

In the stones of a moderate age the cover-glass preparations showed at times organisms more or less degenerated, and which did not grow on culture-media.

The fresh stones almost invariably gave positive results, both on cover-slips and in cultures, the organism isolated being with but one exception the colon-bacillus.

After finding that bacteria were present in the stones, the authors made a series of careful experiments with sterile stones, which showed that these could not be penetrated by the colon-bacillus when subjected for a considerable length of time to liquid cultures of this organism.

They conclude that cholelithiasis is of infectious origin, the stones being caused by the presence of the microbes found within them. Different micro-organisms may cause the formation of biliary calculi, but by far the most common one, both in man and animals, is the colon-bacillus.—*Comptes Rendus de la Société de Biologie*, February 14, 1896.

.PSEUDO-GENERAL PARESIS OF HEPATIC ORIGIN

JOFFROY, at a recent meeting of the Hospital Society of Paris, spoke of a form of pseudo-general paresis which accompanied diseases of the liver.

He reported the case of a sea-captain, of alcoholic habits, who was subject to attacks of jaundice. This individual was suddenly taken with difficulty in walking, and had an apoplectiform attack, following which he remained in an apathetic state, and had some motor disturbances of the tongue and lips, in the form of a suction movement. His speech was slow and rather scanning, similar to that of disseminated sclerosis. A diagnosis had been made of general paresis, with which Joffroy did not agree, as fibrillary twitchings of the tongue and lips were absent and the pupils showed no inequality. The examination of the urine showed the presence of urobilin, and a diagnosis was made of mental derangement secondary to disease of the liver.

This diagnosis was justified by the almost complete disappearance of the mental symptoms following an amelioration in the disease of the liver, and by the fact that a relapse of the mental condition occurred on the patient lapsing into a condition of grave icterus, in which he succumbed.

Joffroy calls attention to the fact that while mental symptoms dependent on disease of the liver have long been recognized, there have been none observed which so closely resembled general paresis.—*Gazette Médicale de Paris*, January 18, 1896.

SURGERY.

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CRANIECTOMY, WITH THE AFTER-HISTORY OF TWO CASES.

T. TELFORD SMITH reviews the subject of craniectomy, and reports the after-history of two cases (*The Journal of Mental Science*, Jan. 1896).

The operation of craniectomy for microcephalus and idiocy has now been on its trial since 1890, and the cases operated on in France, in America, and in England number about 200, from which it ought to be possible to form some judgment as to the success of the operation, in so far as mental development is concerned.

The information which up to the present has been published as to the after-history of the majority of these cases is meagre in the extreme. We find in some cases "amelioration" or "improvement" reported, but particulars as to the kind and degree of improvement are not stated. Also in the published cases the space of time between the operation and the report is generally too short to admit of a well-founded opinion as to the results really due to craniectomy.

It seems time, however, to urge upon all who have had an opportunity ot observing the after-results of the operation, in any cases in which a sufficient time has elapsed, to publish a full and impartial account of the present condition of the patients, and to contrast it with the condition before the operation.

The weight of evidence so far is, the author thinks, against the operation of craniectomy, as judged not only from the facts learned from an examination of microcephalic brains, microcephalic skulls, and of skulls in which the operation has been performed, but also as judged from the actual, mental, and physical results obtained in even those cases in which all the circumstances were favorable.

The first case described may be taken as a fair test-case as to the merits of the operation in microcephaly. He was in every way a favorable case to commence with, healthy and well-developed, with apparently nothing except the microcephaly to account for his mental deficiency. He has certainly had an ample amount of the bony brain-case removed in the five operations he has undergone; and since he has had every advantage and opportunity as regards special training and education. Yet nothing further can be attributed to the operations than the cessation of head-knocking, and though this is a distinct improvement in the boy's condition, yet it hardly seems an adequate result for the risk run. As to mental development, there is very little, and what there is would have most likely been attained by educational methods alone.

The second patient, although hardly falling into the class of microcephalic idiots, was a good test-case as to the advisability of the operation in congenital idiocy. It is impossible to see any mental improvement or sign of brain-development in this boy, and the author thinks in a similar case the operation would now rightly be considered unjustifiable.

SHOULD THE APPENDIX BE REMOVED IN EVERY CASE OF APPENDICULAR ABSCESS?

J. WILLIAM WHITE, after referring to many interesting and important points concerning appendicitis that need further investigation (*University Medical Magazine*, March, 1896), alludes to others that he believed had been settled. Among the latter are the following indications which call for operation:

Immediate operation is indicated whenever the onset of a case of appendicitis is marked by both suddenness and severity; whenever, during even a mild attack, the symptoms at the end of forty-eight hours are unrelieved or are growing worse; whenever, in cases seen later, a firm, slowly forming, well-defined mass is to be felt in the right iliac fossa; whenever at any time a sudden increase in the acuteness of the pain and a rapid diffusion of tenderness occur; whenever there is good reason for believing the appendix-infection to be tubercular in character; whenever attacks of any type have been numerous, or are increasing in either number or gravity, or have unfitted the patient for work or activity, or have caused local symptoms which are permanent and persistent, or have at any time put the patient's life in great danger.

These are not considered exhaustive, but represent in general those that are undisputed.

In regard to the very important problem of the proper procedure in cases of appendicular abscess, the author quotes his views as expressed in a previous contribution on this subject (AMERICAN JOURNAL OF THE MEDICAL SCIENCES, January, 1894).